TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ikechukwu J. Obih, M.D.

Respondent Name
Zurich American Insurance Company

MFDR Tracking Number
M4-17-0856-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Service codes and CPT codes are not to be bundled nor compounded and are to be billed and reimbursed separately and independently from one another. You will note in the attached narrative report and testing results all required and billed components were performed and documented and appropriately utilizing the above TDI-DWC Fee Guidelines and should not be reduced … Per the attached, CPT Code 95885 and/or 95886 can be reported up to a combined total of four (4) units of service per patient."

Amount in Dispute: $401.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bill was processed timely and proper payment made. Please see the EOB(s) and the reduction rationale(s) stated therein."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2016	Evaluation & Management, new patient (99204)	$260.90	$0.00
March 26, 2016	Needle Electromyography, each extremity (95886)	$141.08	$141.08
March 26, 2016	Nerve Conduction Studies, 7-8 studies (95910)	$0.00	$0.00
March 26, 2016	Electrodes, per pair (A4556)	$0.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers' compensation state regulations/fee schedule requirements.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What are the services in dispute?
2. What are the applicable rules for this dispute?
3. Is Zurich American Insurance Company's reason for denial of payment for procedure code 99204 supported?
4. What is the total reimbursement amount for procedure code 95886?

Findings

1. Ikechukwu J. Obih, M.D. included procedure codes 99204, 95886, 95910, and A4556 on the Medical Fee Dispute Resolution Request (DWC060). Dr. Obih is seeking $0.00 for procedure codes 95910 and A4556. Therefore, these services will not be considered in this dispute. Dr. Obih is seeking $260.90 for procedure codes 99204 and $141.08 for procedure code 95886. These services will be reviewed in accordance with applicable rules and guidelines for this dispute.

2. Reimbursement for the disputed codes is subject to the fee guidelines for professional medical services found in 28 Texas Administrative Code §134.203(b)(1), which states, in pertinent part:

   > for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following:
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…

3. Zurich American Insurance Company (Zurich) denied disputed procedure code 99204 with claim adjustment reason code 236 – "THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NCCI OR WORKERS COMPENSATION STATE REGULATIONS/FEE SCHEDULE REQUIREMENTS." The division finds that procedure code 95910, billed by Dr. Obih on the same date of service, has a global status of "XXX." Chapter I of the General Correct Coding Policies for *National Correct Coding Initiative Policy Manual for Medicare Services*, section D, effective January 1, 2016 states, in relevant part:

   > Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code … **With <u>most</u> "XXX" procedures, the physician may, however perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code** [emphasis added]**.** This E&M service may be related to the same diagnosis necessitating the performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. **Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding** [emphasis added].

   Review of the submitted documentation does not find that Dr. Obih appended modifier 25 to procedure code 99204 in the billing process, signifying that the service was a significant, separately identifiable evaluation and management service. Therefore, Zurich's denial reason is supported. Reimbursement for this service cannot be recommended.

4. Zurich reduced payment for procedure code 95886 citing claim adjustment reason code P12 – "WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT." 28 Texas Administrative Code §134.203(c) states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The maximum allowable reimbursement (MAR) is calculated by substituting the division conversion factor. The division conversion factor for 2016 is $56.82.

For CPT code 95886 on March 26, 2016, at the billed location, the relative value (RVU) for work of 0.86 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.876340. The practice expense (PE) RVU of 1.68 multiplied by the PE GPCI of 1.006 is 1.690080. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.955 is 0.038200. The sum of 2.604620 is multiplied by the division conversion factor of $56.82 for a MAR of $147.99. This total is multiplied by 2 units for a total reimbursement of $295.98.

Review of the submitted documentation finds that the insurance carrier paid $148.00. Dr. Obih is seeking an additional $141.08. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $141.08.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $141.08, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	January 11, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.